Medicare Crossovers

Medicare Crossovers

Claims crossover automatic from COBC-GHI.

What does cross over.

- Institutional Claims
- Professional Claims

What doesn't cross over (exempt).

- Part C
- Hospice
- Non-assigned Medicare claims
- Adjustments from Medicare
- NCPDP Claims

Claims That Do Not Crossover

Options

- Bill electronically with appropriate Medicare qualifiers and data included in transaction.

- Bill electronically with PWK indicator and send Medicare EOB as paperwork attachment.
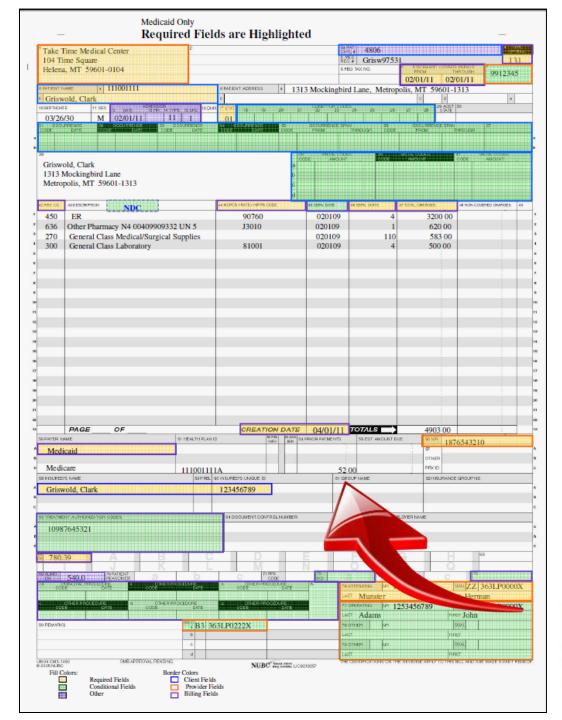
- Bill on paper forms.

Paper Billing

Institutional

- Use form locators 39–41 for coinsurance and/or deductible.

- Paid amount in form locator 54
    - No EOB required for paid claims.

- Denials must have Medicare EOB with Reason and Remark codes description of Reason and Remark codes attached.
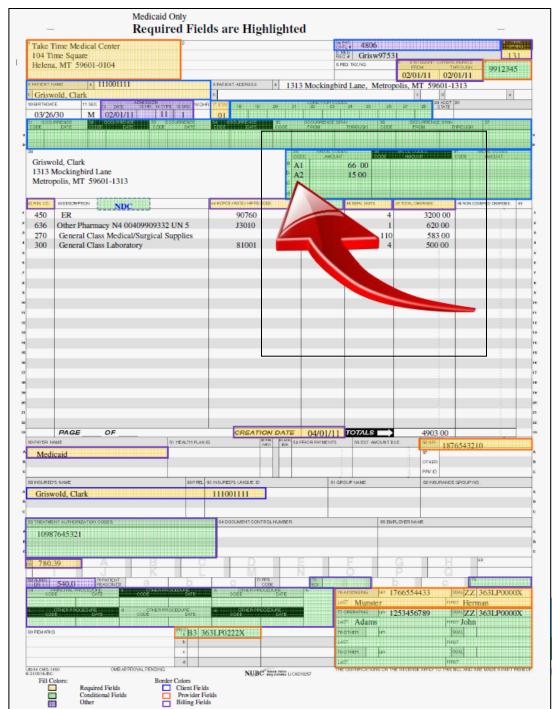
Medicare Paid Amount

Medicaid Only
Required Fields are Highlighted

42 REV. CD.	43 DESCRIPTION	NDC	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
450	ER		90760	020109	4	3200 00	
636	Other Pharmacy N4 00409909332 UN 5		J3010	020109	1	620 00	
270	General Class Medical/Surgical Supplies			020109	110	583 00	
300	General Class Laboratory		81001	020109	4	500 00	

Take Time Medical Center
104 Time Square
Helena, MT 59601-0104

CRTL # 4806
MED REC # Grisw97531
131

PATIENT CONTROL PERIOD FROM 02/01/11 THROUGH 02/01/11
9912345

PATIENT NAME 111001111
PATIENT ADDRESS 1313 Mockingbird Lane, Metropolis, MT 59601-1313
Griswold, Clark

BIRTHDATE 03/26/30 SEX M ADMISSION DATE 02/01/11 HR 11 TYPE 1 SRC 1 STAT 01

Griswold, Clark
1313 Mockingbird Lane
Metropolis, MT 59601-1313

PAGE OF CREATION DATE 04/01/11 TOTALS → 4903 00

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1876543210
Medicaid				57 OTHER
Medicare	111001111A	52 00		PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Griswold, Clark		123456789		

63 TREATMENT AUTHORIZATION CODES
10987645321

780.39

540.0

76 ATTENDING QUAL ZZ 363LP0000X
LAST Munster FIRST Herman
73 OPERATING NPI 1253456789
LAST Adams FIRST John

89 REMARKS B3 363LP0222X

US-04 CMS-1450
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Fill Colors:
- Required Fields
- Conditional Fields
- Other

Border Colors:
- Client Fields
- Provider Fields
- Billing Fields

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Medicare
Coinsurance and Deductible

Paper Billing

1500 claim form

- Do not enter Medicare information on 1500.

- No Medicare paid amount in field 29.

- Attach a copy of the Medicare EOB for all paper claims submitted.

- Include Reason and Remark code description for all Medicare denials.

Part C Medicare HMO Plans

Currently processed as Medicare Part B claims.

- Copay amounts entered as deductible
- Coinsurance entered as coinsurance
- Deductible entered as deductible
- Deductible + Coinsurance + Copay entered as deductible
- Claims processing system cannot process Medicare correctly without a Medicare paid amount if a coinsurance is present
- Medicare paid and deductible/coinsurance all considered in pricing formula.

Common Issues Resulting in Denials

- Client has Medicare on file, and no Medicare information is present on claim.

- Medicare EOB and claim do not match.

- EOB for other insurance states Medicare in the header

- Medicare denied service as: not medically necessary, duplicate, billing error, timely filing, services not paid separately

Third Party Liability (TPL)

TPL Responsibilities

- Insurance verification

- Assist with problem claims

- Retro Medicare

- Carrier billing

- Provider checks/refunds

- Credit balance

- Trauma investigations

Services to You

Pay and Chase

- 90 Day Rule – Providers can request that Montana Health Care Programs process the claim and subsequently bill the other payer.

- Specific circumstances result in automatic pay-and-chase.

Blanket denial

- Include documentation that the client's other insurance never pays for a particular service.

- Requests are available on the web or from TPL. Complete and return requests to TPL.

  - Fax to 406-442-0357.

- In return you will receive the blanket denial along with a tracking reference number to be used for billing.

MONTANA
DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Request for Blanket Denial Letter
State of Montana Medicaid

Effective Date Requested _____ Provider/NPI _____

Client Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____

2. _____

3. _____

4. _____

5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

Fax all requests to (406) 442-0357.

Request must include an explanation of benefits (EOB) stating the services are not covered.

Updated 072012

How to bill using a blanket denial

Xerox staff work TPL edits that post for which a blanket denial has been created.

- **Electronic claims**: Include PWK indicator.
- **Paper claims**: Send the claim only.

Blanket denials are valid for two years from date on the request. Renewals must be requested and are not automatic.
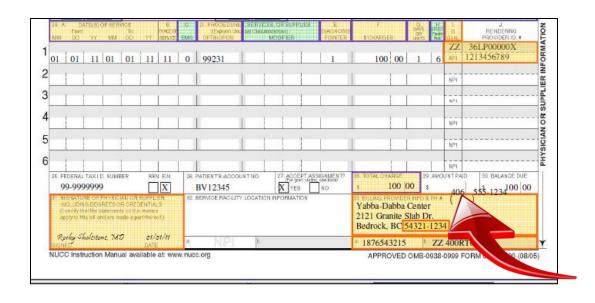
Common Problems

- No TPL amount on the claim

- Medicare information is put in as a TPL amount

- No paperwork attachments

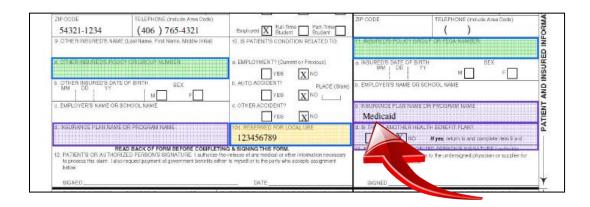 - If you have information TPL has termed, please call Provider Relations at 1-800-624-3958

Phone number read as TPL

- CMS recommended font size is 10 picca

- Paper feed issue

- Common issue automatically resolved by Xerox

Medicaid entered as other insurance

- Field 11c reserved for TPL policies

- Delay claim processing

- Medicare is not considered TPL

What should I send to TPL?

- Problem TPL claims

- 90 day pay and chase claims

- Verification requests from TPL

- Blanket denials

- Refund checks

  - Note if it's for credit balance

Contact Information

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406-457-9530

Donald.raulston@xerox.com

Questions?